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EDITORIAL

The refresher course plays an essential part in maintaining a high standard of nursing. A nurse needs new ideas, new techniques, sometimes a new approach, if she is to be able to carry out intelligently all the procedures ordered by the doctor, or to discuss with a patient, who has seen it on television, the latest treatment for his illness.

For midwives in England and Wales, attendance at a refresher course at least once every five years is compulsory under the rules of the Central Midwives Board. There has not yet been any similar statutory requirement for district nurses and health visitors, although the importance of courses for them arranged by the Royal College of Midwives, the Royal College of Nursing and the Queen's Institute of District Nursing is recognised by the Ministry of Health and by local health authorities, who allow them to rank for a grant. In addition, working parties appointed by the Minister of Health have recommended that district nurses and health visitors should attend refresher courses at intervals of not more than five years, and the Queen's Institute endorses this view.

The Queen's Institute has increased its courses for district nurses who are state registered nurses from two to four this year, and seven such courses will be held in 1962. In addition to these general courses, there are a number of specialist courses for administrators, for male nurses, and for state enrolled nurses; and there are others on particular subjects, such as mental health (see page 65 of our June issue).

The district nurse, then, has a wide choice when the time comes for her to bring her professional knowledge up to date. But the advantages of attendance at a refresher course extend beyond that. A good, well-planned course can be stimulating, especially for the nurse from a single, rural district, who for a week has the opportunity of both formal and informal discussion on a wide range of nursing and welfare subjects, with nurses from many different parts of the country. She will return to her district mentally refreshed and with revived enthusiasm and wider horizons.

As this issue of *District Nursing* appears, eighty-six district nurses are half-way through a week's refresher course which the Queen's Institute has arranged in Cardiff. We are glad to bring before a wider audience the opening address which was given by a general practitioner, and the lecture by a professor of the Welsh National School of Medicine, University of Wales.

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From the inaugural address at the refresher course for district nurses arranged by the Queen's Institute at Cardiff

Patients, Nurses and Doctors

by **GERALD F. PETTY**, T.D., M.R.C.S., L.R.C.P.
General Practitioner, Cardiff

IN the title of this address, you will note there are three personalities, patients, nurses and doctors. I have put them in their order of importance. Without patients, neither nurses nor doctors are necessary.

I am going to take you through the changes that have existed in my lifetime, as a doctor. They are important changes, changes I hope for the betterment of our first priority, the patients. There have certainly been changes for the betterment of nurses, which is our second priority. Whether there have been changes for the better in our doctors I leave to your most excellent good judgment, practical knowledge and experience.

When I started in general practice about thirty years ago, there were a number of extremely practical and very good midwives, the daughters of midwives before them, with a wealth of experience and practical knowledge and ability. They have made the title of "Old Mother Gamp" a disgraceful libel. At the beginning of my career, you must remember we had no sulphanamide drugs, no M. & B., no penicillin; nothing except hygiene, nursing care and the close watch over a patient for a change in symptoms. There were only six real drugs available, morphine, quinine, ergot, digitalis, aspirin and arsenic. Looking around me, it quite amazes me that we have managed to survive with such an incredible lack. Today, the fantastic, miraculous wealth of new drugs tends to be taken rather for granted, and, as a result of the lessening importance of most infectious diseases, I find there is not that strict, stringent hygienic care with which I was so familiar as a young man, particularly in cases of midwifery.

How many midwives today swab the baby's eyes as soon as the head is born? How many midwives today put silver nitrate drops into the eyes immediately after birth? And after all, basically, is it necessary today?

The post partum haemorrhage called for immediate practical action. Transfusion was almost non-existent. It was only used in the planned emergency and even then some mothers died. The blood groups were all correct, but the Rhesus factor had not yet been discovered. I was taught and I still believe, that mismanagement of the third stage is the common cause of post partum haemorrhage, too long a delay in the second stage followed by too much hurry in the third.

In melaena neonatorum we did strange things, 5 c.c. of a nursing mother's blood injected subcutaneously into the baby's back. For some reason the baby got well.

The doctor took a far greater part in the confinement than he does today. The confinements were shorter too. He got a reputation for his frequent forceps delivery; no question of waiting one hour in the second stage.

The doctor gave morphia in the early stages of a confinement, or sometimes throughout the entire confinement. "Twilight sleep", a romanticism hiding the name of morphia and hyoscine given frequently by injection, blotted out the mother's memory and sometimes the child too in white asphyxia. He gave the mother an anaesthetic, usually chloroform. The gas and air machine only came into general use just before the war. The doctor was a necessary appendage to the drama of a confinement. Today he is not.

Progress in Midwifery

In the last decade there has been a considerable change in the practice of midwifery, for several good reasons.

One of the main reasons is the Dangerous Drugs Regulations, 1953, which empower midwives to possess and to administer medicinal opium, tincture of opium and pethedine.

Secondly, the gas and air machine has replaced the old chloroform capsules and the final anaesthetic when the head is on the perineum.

Thirdly, infinitely more detailed care of the pregnant woman in our clinics makes the domiciliary emergency a rare occurrence; anybody likely to give trouble goes to hospital.

From the patient's point of view and from the nurse's, this new state of affairs marks a step forward in progress. At the same time I think doctors should be present far more than they are today at the actual delivery. If you are not frequently seeing the normal, the abnormal becomes more difficult to recognise early and the decision to interfere can be left too late.

Midwives today are better taught, better equipped, and better able to deal with normal deliveries than ever before. What a difference since I was a Bart's student "on the district". No supervised practical training, out to a multipara eight, often no nurse, in a hovel teeming with bed bugs, we wore a mask, gloves and gown. What scientific bacteriological bathos! The curious thing was that the mother did well, there was seldom any pyrexia, and the babies thrived. Atypical staphylococcol gastro-enteritis cases were not heard of.

There were plenty of other things from which people could and did die. My old teacher, Dr. Langdon Brown, told us that when he was a house physician at the Metropolitan Hospital, there was a rule that *not more than two cases* of typhoid were to be admitted to any general ward. In my day, the young and the old died of lobar pneumonia. Infectious fevers took their toll. The expectation

of life after reaching the age of sixty was fifteen years less than it is today.

This fact brings me to the patient and the district nurse. There is an ever increasing need for the district nurse. Again, she, like her midwife colleague, does far more than her predecessors. The old people are living longer. A changing social age has dimmed responsibility within the family.

"Doctor something must be done. You've got to get Mother into hospital".

"Daily nursing care, please Sister".

This may include injections of insulin for the helpless, or the lazy-minded who cannot be taught part of their daily duty. Is this always right? The diabetic clinics teach the patient the reasons for his disease and how to look after himself. The old tradition of the district nurse was *not* to do everything for the patient, but to train the patient and the patient's family how to do it.

There is far too much demand from the public today, who grow more helpless and less self-sufficient. More and more they make demands particularly in the industrial areas, on doctor and nurse. "I have a headache, doctor, is it safe for me to take aspirin? A Sunday paper says it gives one ulcers".

The word doctor means teacher. If we are to give efficient service, nurses must teach relatives, as they used to do. Instruct them in blanket bathing, prevention of bed sores, taking of temperatures and the normal care of the sick and aged. After that, an occasional advisory visit should be all that is really necessary.

The acute case falls into a different category. Injections of penicillin and general nursing care over the severe phase of the illness are most important and save a hospital bed. Close contact with the doctor is essential. Good nursing means skill in observing changes in the patient. Tell the doctor. Don't worry if he gets the credit for making the right diagnosis.

A Paradox

The acute case also includes the dying case. Carcinoma of the lung, the present ravager of our time, makes necessary daily visits in the terminal stage. Morphia by injection, aided by largactil, eases the patient comfortably out. The regular twice-daily visit by nurse and frequent visits by the doctor to increase steadily the amount of morphia required brings comfort to all. Morphia never shortens life. It prolongs it.

Paradoxically, blindly, perhaps stupidly, we prolong life. Should we blindly prolong life? We are not God to decide when to terminate it. Every nurse has been begged to shorten the agony, every doctor too.

For the hopeless case, if a doctor, or relative, wants to give the patient some odd "cure", always agree that it is worth trying. Hope deferred eases the burden of eventual bereavement.

The chronically ill patient, for whom nothing can be done, is always the most difficult to visit. Nurses and doctors sometimes feel the visit is a waste of time. The "human cabbage" without mind or movement, still means something to a devoted daughter. Encourage and congratulate her on her nursing care.

This brings me to another aspect of nursing: the psychological and the mental.

An ever increasing number of psychotic patients will be looked after at home, thanks to the new Mental Health Act and its doubtful blessings and thanks to new groups of drugs, the pheno-thiazines and the monoamine oxidase inhibitors (the tranquillisers and the anti-depressants).

The trials of these new drugs are in their infancy, but the prospect of converting a deluded, dangerous, psychotic to a normal person is with us now. E.C.T. and insulin shock therapy will be the thing of the past. The confabulating, muttering, wandering old person is no longer incurable.

In wiping out a number of diseases, and prolonging life, we are now about to succeed in being able to grow old young.

At present, fifty-one per cent of the total hospital beds in the entire country is taken up by the mental hospitals. It may well be that a change will take place. Ten years ago it was difficult to get a patient into a T.B. sanatorium. Now, most are closed and the patient is treated at home with P.A.S., I.N.A.H. and streptomycin. The children's wards are half empty, with the advent of the sulphanilamide drugs and antibiotics. Our fever hospital here is largely devoted to gynaecological and geriatric cases. Ear, nose and throat surgery has dropped by three-quarters.

So, too, it will be with mental patients, and there will be more work outside for doctor and nurse. In the City Mental Hospital at Whitchurch there are one hundred patients fit for discharge home. There is no room at home. This appalling lack of family responsibility is something that you are familiar with. It is something that nurses, more than priests, doctors, laws, or regulations, can do a lot to improve. A few sharp, salutory words to the family on the care of Mum or Dad in every other home you go to, will do much more good.

I look on the role of nurse as that of teacher to the family. Some of you may become health visitors, or mental welfare visitors, as envisaged under the new Mental Health Act, where the responsibility for the subnormal is now vested primarily in the local health authority. The mentality of the senile member of the family is

Miss Olwen Ashton, Q.I.D.N. district nursing officer for the Midlands and Wales, is in attendance at the Cardiff refresher course. Miss Ashton, who is Welsh-speaking, has sent us the following message:

"CROESO i GAERDYDD i'r Cwrs Ychwanegol i Weinyddesau Cylch, y cyntaf i'w gynnal yng NGHAERDYDD."

"Welcome to Cardiff to a refresher course for district nurses, the first to be held in Cardiff."

made worse by being disturbed out of his normal routine. The old grow more emotional and more easily hurt. Occasionally, like children, the reverse happens and they get spoilt, becoming absolute tyrants, wrecking the second and third generation.

Finally, on the mental side, we have in this country a high suicide rate. The hysteric, who threatens suicide to get her own way, never does so. It is the person that you had a normal conversation with at lunch, who is dead by teatime. Depression is normal to us all. The neurotic is either on top of the world, or down in the dumps. If we fail to deal with the anxieties and difficulties in our environment, we have a normal depression, or we may even get ill.

The common cause of headache is anxiety, the second common cause is constipation. The quiet person, who wakes up depressed every morning and whose depression may be somewhat alleviated during the latter part of the day, is the person suffering from what has been called an endogenous depression, which basically means a depression where physical changes have occurred in the brain. The amount of depression may be out of all proportion to the anxieties of the individual. The normally depressed, over-anxious individual, often gets depressed later on in the day, particularly when he gets a bit overtired, and this is one of the main differences. It is of the utmost importance to get the person suffering from an unrelieved depression, to a psychiatrist, or doctor. There are now specific drugs to relieve this depression: niamid, nardol, parstelin, tofranil, fentazin, to name only a few tranquillisers and monoamine oxidase inhibitors.

The national health service was quoted in one of the London dailies in large block headlines, as the "national dope service". It has enough truth to sting. We have become a nation of tablet takers. There are six thousand proprietary preparations on the chemists shelves today. As you know, every household has its colourful array of bottles.

I tell every mother, when I prescribe tablets "Put your tablets out of reach of the child and if the child swallows them, don't send for me, take him straight to the hospital".

When you go into a home where the tablets are on the table, never fail to tell the mother to put them back on the topmost shelf, well out of reach.

After a death in the family, there are innumerable boxes of pills to deal with. What do you do with these? The official answer from the Ministry is that legally medicine and tablets are the property of the patient. After death, all drugs should be destroyed. Dangerous drugs, phials of insulin etc. should be returned to the doctor for onward transmission to the Executive Council.

In conclusion, I would like to stress the importance of the fact that we are working in a team. We are part of a magnificent and most expensive experiment in the history of mankind. The national health service is full of faults. A great many of these can be remedied by those who feel dedicated to the task of seeing the public gets the best possible service. I would re-emphasize just two things: co-operation all the time between nurse and doctor; and the role of teacher, which the nurse should be to the family, in the care of the sick in mind and body.

Birthday Honours

Our congratulations to the following:

Dr. G. W. H. Townsend—C.B.E., county medical officer, Buckinghamshire.

K. H. Brill—O.B.E., children's officer, Devon.

Miss K. A. C. Gillie—O.B.E., general practitioner, Paddington.

H. A. Goddard—O.B.E., chairman, management side and alternating chairman, Nurses and Midwives' Whitley Council.

J. G. Ollerenshaw—O.B.E., general practitioner, Skipton.

E. Scott—O.B.E., general practitioner, Ashford, Kent.

Miss M. D. Stewart—O.B.E., secretary, Scottish Board, Royal College of Nursing.

Miss A. N. Carruthers—M.B.E., district nurse, Amble, Northumberland.

Miss E. G. Gurney—M.B.E., health visitor, Surrey.

Miss E. Passmore—M.B.E., Nursing sister of Bush Nursing Centre, Jindabyne, New South Wales, Australia.

Mrs. E. V. Thomason—M.B.E., president, district nursing association, Queensland, Australia.

J. E. Westmoreland—M.B.E., mental health officer, Nottingham.

C. F. Williams—B.E.M., surgical dresser, public health department, St. Helena.

THE ENROLLED NURSE

FROM this month, 70,000 enrolled assistant nurses, the vast majority of whom are women, are entitled to call themselves enrolled nurses and to add after their names the initials S.E.N., thus dropping the word "assistant". This is a result of the Nurses (Amendment) Act, 1961.

A Ministry of Health spokesman commenting on the change, said: "It had been increasingly felt that the word "assistant" in the official title underestimated the importance of these valuable nurses. They are working not only in all types of National Health Service hospitals but also in the local health authority nursing services as well as in clinics."

It is felt that this change of title will enhance the professional status of the assistant nurse, and should help recruitment.

The new Act also increases the size of the General Nursing Council and makes changes in existing professional disciplinary procedure for nurses on the lines recommended in the Simonds Report. It gives power to subpoena witnesses, administer oaths, and appoint a legal assessor to advise in proceedings for the removal of a person from the Nurses' Register, Roll or List.

The Act also applies to Scotland.

From the first lecture at the Cardiff refresher course

The Changing Pattern in Children's Diseases

by **A. G. WATKINS**, M.D., F.R.C.P.
Professor of Child Health, Welsh National School of Medicine

THERE is no doubt that the children of this generation are far more healthy than their parents before them and certainly more so than their grandparents. The average baby today attending our infant welfare clinics is healthier, better clothed, better mothered and even heavier than his uncles and aunts were twenty to thirty years ago.

There is of course, no single reason for this great improvement in child health, but one must include the following as important contributing factors:

(*a*) The realisation of the importance of positive health and the education of mothers and others in the art and science of infant nurture.
(*b*) The change in the incidence of disease, especially the infectious fevers as the result of our immunisation programmes.
(*c*) The improved social conditions of our people.
(*d*) The great advances in medical science which have enabled us to understand better the various disease processes, especially perhaps in the understanding of biochemical disorders.
(*e*) The introduction of antibiotics, both curative and preventive in the control of infections.

There has been a gradual change in our conception of what is meant by good health and this has been brought about largely by education and teaching of parents at infant welfare clinics, school clinics, in the homes by district nurses and health visitors, in hospital and through public propaganda on the radio and television. With the lessening of disease we have more time to pay to this important aspect of our work; remember the word "doctor" means "teacher". There is no doubt that the deficiency diseases of rickets and scurvy have disappeared because of the preventive advice given to mothers of young babies. When they do occur, someone has blundered. The only common deficiency disease today, in this country, is an iron deficiency anaemia. This is most likely to follow a premature or twin birth and should be prevented by regular oral iron.

Immunisation has brought about the virtual disappearance of diphtheria and smallpox and the lessened severity of whooping cough. Scarlet fever has lost its virulence and measles now accounts for more deaths in this country than any other exanthem; there is hope that a measles vaccine may be forthcoming. Poliomyelitis is coming under control and should soon disappear. All this is reflected in our empty fever hospitals.

Improved social conditions have perhaps played the greatest part of all in our better health and in that of our children in particular. A visit to any of the "underdeveloped countries" where the killing diseases are gastro-enteritis and malnutrition, will show how impossible it is to deal with disease by medical care alone. Housing, overcrowding, clean water supply, lessening the birth rate, good food and breaking through the barriers of tradition and superstition are the major problems. In this country, the reduced incidence of tuberculosis and rheumatic fever, to mention only two examples, is largely the result of better social conditions, though no one will deny the part that drugs have played too.

There has been tremendous progress in advances in medical science since the last war. Infection apart, we can now control such conditions as pernicious anaemia and coeliac disease; and many of the congenital defects, notably those of the heart, are amenable to corrective surgery. So also are many of the defects of the alimentary tract and pyloric stenosis is no longer the only one the surgeon cures. The old belief that it was dangerous to operate on a very young baby is no longer true, for they stand the onslaught of the surgeon as well as if not better than older children, provided the correct supportive treatment is given.

Among the outstanding advances in paediatrics are the following:

Coeliac Disease: The discovery that this disorder was really an in-born error in the child's ability to deal with the gluten fraction of certain starches, has led to a gluten free diet with a remarkable response in these children.

Fibrocystic Disease, which was often diagnosed as coeliac disease, is still a most difficult one to treat, but with careful management many cases, although alas not all, can be helped and more patients are surviving to adult life.

Phenylketonuria is a very rare condition occurring in about one in 25,000 births. We now know that if a baby is borne with the biochemical inability to convert the phenylalanine in his normal diet to tyrosine, then the resultant intermediate products produce body and mental changes. If the diet can be free of phenylalanine, though this is difficult to do, then there is a prospect that mental defect may be prevented or lessened. The discovery that mental defect may have such a biochemical origin is a great advance in our understanding of this difficult problem and may lead to greater things.

Galactosaemia is another such disease in which there is a disability in the metabolism of galactose, a constituent of milk and lactose containing foods. Here, too, the removal of lactose from the diet may prevent mental change.

Congenital defects: reference has already been made to the advances in surgical techniques for some of these

anomalies. More fundamental is our increasing knowledge of how some of these are caused, which may give us a clue to their prevention. The best known of these is the production of such defects as cataracts and heart defects following german measles in the first three months of pregnancy.

A great deal of experimental work on animals has shown that certain noxious substances, if injected into pregnant animals, may result in congenital defects of the offspring, e.g. trypan blue, insulin, alcohol and even cortisone. Vitamin deficiencies such as no vitamin A or riboflavin in the diet of pregnant rats may lead to cleft palates in the litter. Skeletal deformities and cerebral damage may follow anoxia. All these experiments point to possible ways in which the intra-uterine environment may affect the developing foetus.

To this knowledge must be added a great deal that has been learnt in genetic problems, not the least the identification of chromosome patterns and the discovery that certain so-called congenital changes, such as in mongols, may be associated with a change in the chromosome count.

In the field of antibiotics there has been perhaps the most dramatic advance, especially against the streptococcus, the pneumococcus and venereal disease. Pneumonia in older children or adults is no longer the dreaded disease it was, though we still lose small babies with bronchopneumonia and virus bronchiolitis. The next great advance will be the control of virus infections.

The infections that used to fill our hospital wards are now seldom seen and such conditions as osteomyelitis, mastoiditis, empyema and bronchiectasis are clinical curiosities. Tuberculosis in childhood has almost gone, thanks to a combination of better living conditions, antituberculous drugs and B.C.G. The dreaded tuberculous meningitis is now satisfactorily treated in most cases and has become a very rare occurrence.

The natural history of rheumatic fever has changed over the years and with the help of antibiotics for the initial streptococcal infection, and more hygienic homes, this disease has become much less common and much less damaging to the heart. This means, amongst other things, that mitral stenosis in adults will become uncommon and that many women will avoid the debilitating effects of early rheumatic heart disease in middle age.

A New Balance of Incidence

All this has meant a rearrangement in the balance of the incidence of disease in childhood, and now accidents top the list of causes of death in children between the ages of three and twelve years. Malignant disease, including leukaemia, has become the second most common cause. A remarkable change indeed.

In infants, prematurity is responsible for most deaths, with congenital defects next. It is therefore right and proper that paediatricians should pay especial attention to the care of the newborn and premature babies. Lives can be saved by modern techniques such as exchange transfusion, intravenous feeding, correction of electrolyte imbalance etc., units for special care of premature and other babies, and modern surgery. To these must be added the continued need for expert nursing. The sister in a premature baby unit is still its most important component but she must be trained in modern methods.

With the suppression of diseases, particularly those of infective origin, other conditions come into more prominence. Malignant disease is one, and in children it occurs most frequently in the kidney, brain and blood. Even in the latter we can obtain a remission in the leukaemic process which is an encouragement for the future. Accidents are on the increase on our roads, but lessening in the homes where health advice and propaganda have done something to prevent these catastrophes. That most home accidents are preventable is shown by the fact that it is excessively rare for a second accident of the same nature to happen in the same family surroundings.

During recent years there has been an encouraging surge of interest in mental health. We have learnt to detect abnormal trends early and so help these unfortunate children at the beginning. We have seen how a few cases can be treated and with better and more special schools; many of these children, notably those with cerebral palsy, can be trained to become useful if not fully functioning citizens.

More Psychosomatic Diseases

Our out-patient departments, now deprived of their former "lumps and bumps", contain an increasing number of psychosomatic diseases, e.g. asthma, recurrent abdominal pain and behaviour disorders. These need more than organic medicine for their care. They are time consuming and call for help from social workers, almoners, and health visitors, for they are largely social and domestic problems. Paediatric work is changing but not lessening. We are learning more about the normal child and his deviations from normality, more about his physiological growth and emotional and mental development. Our contribution to child health is different but none the less important.

The hospital pattern has changed too. No longer do we see children kept in hospital for many months, and the need for convalescent homes is disappearing. We admit more cases because their hospital stay is short, and babies and toddlers are sent home the day after operation in order to cut down the risk of hospital infection and to reduce the time of separation from their mother.

To you as district nurses the pattern must have changed too. No longer the tedious and painful dressing of infected wounds, no longer the bed-ridden children with rheumatic heart disease, no longer the "delicate child" or the feeding problems of infancy.

Exceptions there will be and we must always be alert for them. The less we see of acute disease the more difficult it becomes to recognise. Constant vigilance must be our practice and our gratitude must go to all those who have worked in hospitals, laboratories, clinics and not least yourselves in the homes, to preserve and safeguard the precious heritage of a healthy new generation.

For over thirty years, Cardiff has made special provision for those suffering from this disease

Acute Rheumatism in Cardiff

by **W. POWELL PHILLIPS,** O.B.E., M.R.C.S., L.R.C.P., D.P.H.
Medical Officer of Health, Cardiff

ACUTE rheumatism is an extremely interesting disease and one in which there has been a very remarkable diminution in incidence which has occurred over the last twenty-five years.

The precise cause of rheumatic fever is still not definitely known. There is general agreement that streptococcus of Lancefield's type "A" has a close relationship to the incidence of the disease. The organism itself cannot be recovered with any degree of regularity from patients. On the other hand, the disease frequently follows acute streptococcal infection, particularly affecting the upper respiratory tract. Recurrence of attacks of acute rheumatism are now controlled by treating streptococcal infections with appropriate antibiotics. Many consider that acute rheumatism is produced as a result of a hypersensitivity to the organism rather than by direct infection.

The diagnosis may be very straightforward or present considerable difficulty. Most commonly it occurs in childhood between the ages of five and fifteen years. It is also not uncommon in young adults. In its classical form with pyrexia, sweating, pain and swelling in the medium sized joints, accompanied by lassitude in a child who was previously active, the diagnosis causes little difficulty.

More difficulty is encountered where the signs and symptoms are more obscure, with only intermittent or persistent pains in the limb or joint, but with no well defined pyrexia or joint swellings. Occasionally the presence of small nodules in the skin may indicate acute rheumatism.

Purposeless and jerky movements of the arms and legs indicate a reaction of the central nervous system to acute rheumatism. This is known as chorea, or St. Vitus' dance.

Whatever clinical form the disease takes, the underlying danger is rheumatic carditis and this may follow not only the obvious clinical case, but also the much more obscure forms of illness.

The pain and pyrexia can be well controlled by the use of salicylates, but once the cardiac muscle is involved prolonged rest in bed with a very gradual return to activity is of the utmost importance. The careful nursing of the patient is of more importance at this stage than any other form of active treatment. Once a patient has had acute rheumatism it is of great importance that upper respiratory infection should be minimised with antibiotics, to which the streptococcus is sensitive. This also applies where any operations and even dental extractions are carried out.

As a public health problem rheumatic fever has caused grave concern. The illness, in any of its forms, commonly affects the heart, producing a rheumatic carditis; the aftermath of this condition being met with in later life with damaged cardiac valves which ultimately may result in a cardiac cripple. The clinical picture so often resulting is a relatively young adult with cardiac failure at the very time in life that he may be supporting a young and growing family.

In an endeavour to ascertain and adequately treat acute rheumatism in its earliest stages, the Cardiff City Council established a small hospital of some twenty-five beds in 1929. As a result of this, patients were referred to special clinics which were set up in various parts of the city. Children who required treatment were admitted to the hospital and thereafter were kept under observation throughout school life. Paediatricians, general practitioners and the medical staff of the health department co-operated in this scheme for the early ascertainment and treatment of the disease. As a consequence, while there was no formal notification of acute rheumatism, there was a very comprehensive knowledge of the incidence throughout the city.

In 1933 there were no less than 524 new patients brought under observation with a provisional diagnosis of acute rheumatism in one or other of its clinical forms. Probably not all of these cases were acute rheumatism, but a substantial proportion had definite signs of cardiac involvement.

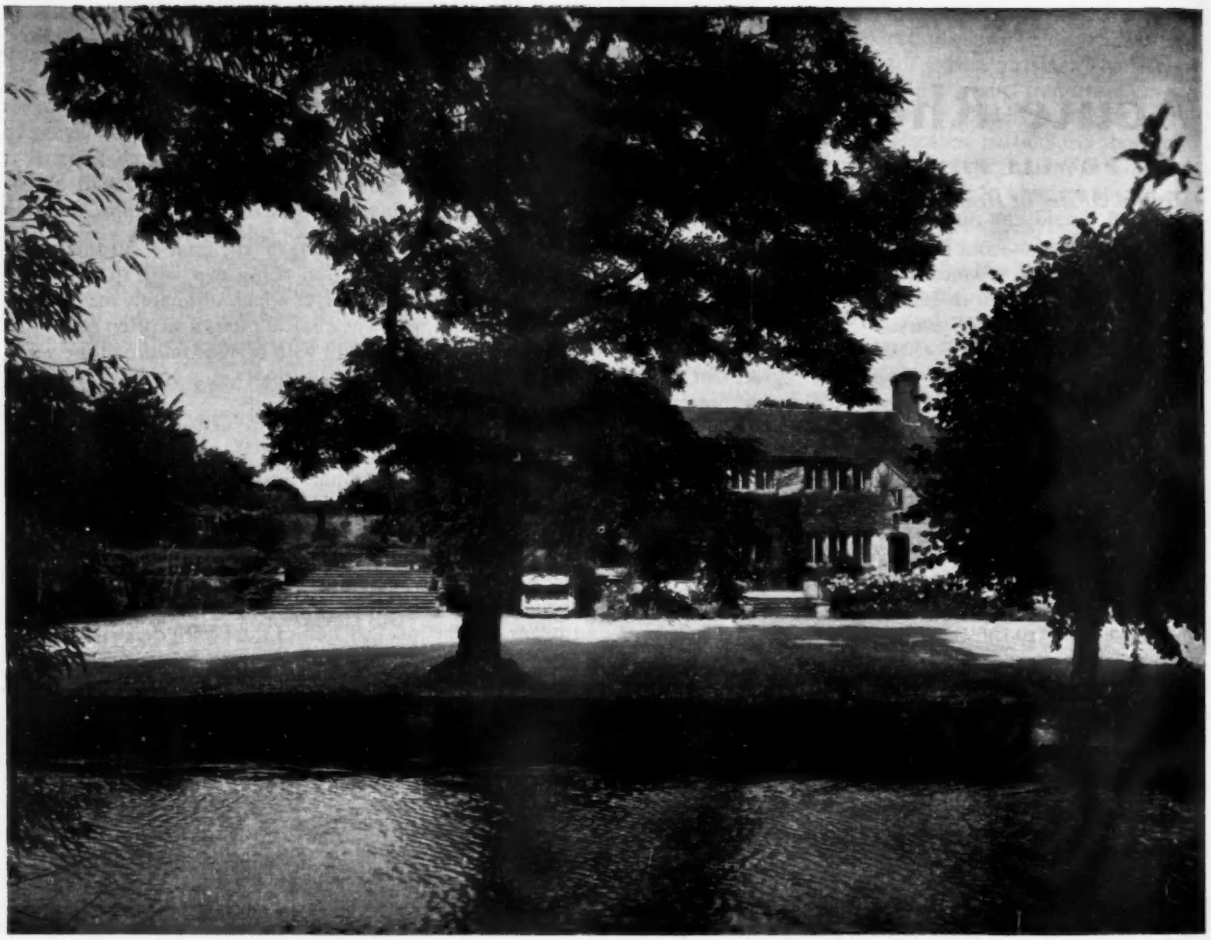
Official Notification

The Acute Rheumatism Regulations, 1953, made it possible for this disease to be formally notified to the medical officer of health. The Acute Rheumatism (Amendment) Regulation, 1959, applied this procedure to Cardiff. In other words, a formal arrangement for notification replaced an informal arrangement which had been in operation since 1929.

Illustrating the decrease in incidence of this illness, only fifteen cases were notified as suffering from acute rheumatism in 1960. All were in the five to fourteen age group. Nine suffered with polyarthritis, with heart involvement; three had active carditis as the presenting symptom, while two had rheumatic chorea alone.

In 1960 the special hospital referred to was no longer required for acute rheumatism and was closed for this purpose. It now deals with chronic diseases of the nervous system.

This is all quite interesting and satisfactory, but it would be even more satisfying if an explanation and reason could be substantiated for this remarkable fall in incidence. It is only possible to speculate on the possible



Photograph by courtesy of Percy Cane

A Trout Pool on the Rother

The Mill House, Fittleworth, Sussex, will be open to the public in aid of The National Gardens Scheme on Sunday 16th July from 2 to 7 p.m. As well as the trout pool, the old mill and the river Rother which runs through the garden, there are delighful herbaceous borders and roses to be seen

Acute Rheumatism *continued from page 81*

factors which have operated and to carefully observe events in the future, especially with a view to taking all means available to prevent a future increase in incidence.

Considering the factors which may have operated, it is well to consider scarlet fever, a specific infectious disease known to be caused by streptococcus pyogenes. In the early decades of this century scarlet fever was a very severe infection. Acute fulminating infection, septic and haemorrhagic scarlet fever were met with undue regularity in epidemics.

The disease is now one of the mildest infections and the severe forms are almost of historical interest only. No explanation can be given for this, but it depends on one of two things operating, either the organism has lost in virulence or the resistance of the population has increased. This change had taken place before the introduction of the antibiotics. This is, very naturally, of some significance in relation to acute rheumatism because another type of streptococcus certainly plays a substantial role in the aetiology of the latter condition.

Have "socio-economic" circumstances changed over this period in such a way as to reduce the incidence of acute rheumatism? It would be gratifying to attribute this betterment as being in some way connected with higher living standards in hygiene, diet and housing. A critical appraisal of the situation when acute rheumatism had a high incidence rate could never pin point any socio-economic factor as being of real significance in relation to incidence.

A Conference held in London on 19th April, 1961 by the Queen's Institute of District Nursing

Central Sterile Supply Services
and their Application to District Work

Principal Speaker: **E. M. DARMADY**, M.A., M.D., F.R.C.P.
Senior Pathologist, Portsmouth and Isle of Wight Area Pathological Service

MANY of you here today may be wondering what is the point of a central sterile supply service. What do we hope to achieve by introducing it?

I would give two answers:

1. We wish to save the nurses' time.
2. We will improve the bacteriological standards of our dressing packs and of our instruments.

One thing we have to realise is that cross infection is no longer confined to the hospital: we have to consider cross infection in the home. We know from our studies that the antibiotic-resistant staphylococcus is now becoming common in the community as a whole, and this, of course, will be likely to affect the district nurse as well as her counterpart or colleague in the hospital. For example, it is the practice in most hospitals to send any patients with antibiotic-resistant staphylococcal infection home as soon as possible in order to prevent spread throughout the hospital. Therefore the patient will come under the district nurse who is capable of carrying the resistent organism from one home to another.

Before we started central sterile supply we carried out a very large survey in association with the Nuffield Provincial Hospitals Trust. We selected certain hospitals which we knew would provide high standards of work, and made observations of various practices. We were privileged to do the bacteriological side of this work.*

Photograph by courtesy of Nursing Mirror

Dr. Darmady, the principal speaker, with members of the audience

The first thing that horrified us was to find that twenty-six per cent of the Cheatle forceps were contaminated. Similarly, although not a very large series of syringes were involved, sufficient numbers were contaminated to make us worried (seventeen per cent). Twenty-one per cent of instruments, bowls and receivers were also infected. All these three items had been sterilised, if we can call it such, by boiling. Finally, we found that twenty-four per cent of the dressings in the drums once opened were not sterile. The cause of this contamination was not far away.

We discovered first, that Cheatle forceps were often put into unsuitable bowls; second, the disinfecting fluid selected was not of the right type and did not cover the joints of the Cheatles; third, as the Cheatles were constantly being used, the time of exposure to the disinfectant was insufficient to disinfect or sterilise them. This made us resolve that when we came to devise our dressing technique, we would not use Cheatle forceps.

We examined the boilers themselves. We soon found that these were often too large and the water took a long time to get to boiling point. Very often the water was not at a sterilising temperature when the instruments were put in the steriliser. I must make it quite clear that it is difficult to judge whether water is boiling or not, since bubbles taken as criteria of boiling start to appear at 60°C.

Perhaps the principal cause was due to the nurses themselves. Because the nurses were busy they found there was no time to clean the instruments or position them properly in the steriliser and as a result bowls were stacked one within another; furthermore because they were in a hurry bowls were taken out too soon. Quite often the nurse was unable to see into the boilers and she would find difficulty in selecting the instrument because of the steam coming up in her face. She frequently selected an instrument which had been placed there by a colleague seconds before. Again, not only were the drums in bad condition but because the nurses had constantly to open and shut the lids of the drums the dressings became infected. We also observed that an unnecessarily large number of dressings were being put out, and very large numbers of towels being used to surround the patient's wound. This has the disadvantage that it stirs up the surrounding air which may carry staphylococcus. We are convinced that all dres-

* Darmady, E.M., Hughes, K.E.A., Jones, J.D., Verdon, P.E., 1959 *Lancet* **1** 622

sings and all operations, should take place in a calm atmosphere with the minimum disturbance of air.

The C.S.S. system that we have introduced in Portsmouth may well be the basis of a system which could help district nurses considerably in their work, and I would like to tell you about it.

The service in Portsmouth arose as a result of a medico-legal case, in which the use of an improperly sterilised lumbar puncture needle caused a severe infection and cost the Portsmouth Corporation £12,000. I am sure you will realise that in a central sterilising unit it is possible to ensure that all instruments and dressings are submitted to a sterilising process, and the process can be supervised and the routine bacteriological tests can be carried out.

Daily Exchange

We started in 1947 by setting up two syringe services, one at the Royal Portsmouth Hospital, and the second at St. Mary's Hospital. We very soon found that this did not work, for various reasons that I cannot discuss here, and we decided that we should centralise our service at St. Mary's Hospital. Furthermore we decided to allocate to each ward or department a fixed number of syringes at a realistic level, which were exchanged daily whether the syringe had been used or not.

We found that it was more satisfactory to use orderlies from CSSD to make the exchange.* This has a public relations value as well, because there is a direct contact between the supervisor on the one side and the ward on the other.

Before we started on full C.S.S.D. service we studied other methods, used both in Europe and in the U.S.A. In most countries, a multiple pack system is used, that is to say a pack is designed for a particular ward technique. Thus a pack contains not only the dressings but towels, all the instruments, and various equipment for any particular procedure. Because of the large number of instruments and dressings they have to be mounted on trays. These trays are bulky, heavy and difficult to carry. Furthermore, they are covered with fabric.

In our experience, fabric is not a good material for maintaining sterility. First: if you examine a piece of linen or balloon fabric as used in an operating theatre, you will be surprised by the many pinholes you can see. Remembering that you cannot see organisms, you can realise how easy it is for organisms to get through. Second: fabric absorbs water: this is indeed dangerous. For organisms are not only carried in water but when mixed with body fluids can multiply. For this reason, we have used paper which is far superior to fabric, since it allows the penetration of steam and maintains sterility.

The system that we have adopted consists of providing a number of a completely disposable pack, which once sterilised, would go to the ward and after use could go to the incinerator. We have found that only three basic packs were necessary for the ordinary standard dressings carried out on the ward. In order to provide for the individuality which nurses and doctors all have, we provide extra materials individually wrapped.

All our basic packs have an outer covering of Kraft paper bag. This helps to maintain sterility. Inside is a sheet of paper which forms extra cover and a sterile field. This paper requires special qualities. First, it must be water-repellent, so that the fluid which might be on the surface on which it is laid, cannot soak through the paper and carry bacteria with it. This is not a very serious problem, because most people do not leave water lying about in their homes, but it might occur in hospital. Secondly, it must have no pinholes; thirdly, it must drape well and lay flat.

The paper we are using is excellent from a bacteriological point of view, but it has not good draping qualities. We hope to improve on this paper later and manufacturers are working hard to provide paper of these qualities. As far as instruments are concerned we provide four pairs of forceps sterilised in an aluminium container. We are also introducing an aluminium container which will take large instruments, which can be sealed in exactly the same way as the syringes. The larger instruments, such as the speculum, may continue to be packed in nylon or paper bags. We use nylon as little as possible now because of expense. An allocation of our dressings and instruments is made to every ward and exchanged daily in exactly the same way as described earlier.

A recent criticism of our methods is that it is not very satisfactory for the dressings to be brought backwards and forwards if they are not used. We are now trying a new idea. A box of fifty dressings is sterilised and sent to the ward and placed in a dispenser. The box stands on end and is so arranged that when the bottom dressing pack is removed, another takes its place. This means that in future we would only have to make a distribution of basic packs once a week, and the dressings would be used in a strict rotation. Our service now covers fifty-two hospitals for syringes and five for C.S.S.D. Delivery is made in four lorries daily.

* * * * *

After Dr. Darmady had shown a film strip on the dressing technique used at the Portsmouth Group Hospitals, *Dr. Patricia Verdon*, M.B., B.S. (part-time Clinical Assistant, Portsmouth and Isle of Wight Pathological Service) showed slides taken during the time and motion study, when district nurses were carrying out a trial using the central sterile supply service.

Commentary:

Nurse, entering a caravan to give an intra-muscular injection, carries one of our syringe boxes under her left arm. In her right hand is a Gladstone bag, containing all her instruments and dressings for her round.

Inside the caravan, Nurse takes the 2 ml. syringe straight out of the box. (We have not provided swabs because the patients have their swabs and the water on the table ready for the nurse.) She draws up the dose and

* The method of exchange and distribution and contents of packs were published in District Nursing, January 1961 (copies still available, price 2*s*.)

Photograph by courtesy of Nursing Mirror

During the afternoon, two district nurses who had taken part in the survey in Portsmouth demonstrated injection and dressing techniques by current and new methods. Here nurse is tipping forceps out of aluminium container onto sterile field

gives the injection. The whole thing is a very quick process. We know she is operating with an absolutely sterile syringe, and she has not had to wait for water to boil and then give it five minutes' boiling, which takes precious time which could otherwise be devoted to bedside nursing.

Further slides illustrated a post-operative cholecystectomy dressing, taken at a patient's bedside, to show average conditions: no clean shining trolley, an ordinary bedside table with a cloth over it. Onto that Nurse puts her main dressing pack, and four forceps in an aluminium container. She cuts off the top of the outer bag and slides out the inner pack of dressings and gallipot which she opens out, providing a sterile field from which to operate. She then adds to the sterile field any instruments she requires from their containers. No more bowls are necessary for holding her dressings, no more receivers for holding forceps and scissors.

She uses the same method as the nurse in hospital. She has managed to clip on to the side of the table a small polythene bag to take her dirty instruments. If this is not possible, then she stands the bag in a disused basin, which a lot of patients put ready, or else a glass jam jar on the floor. These polythene bags of dirty instruments are placed in a dirty bag carried by the nurse or can be placed in the outer pocket of the traditional Gladstone bag, which is kept as the dirty container and wiped out each evening. The instruments can remain in the dirty bag all day without soaking through, as the polythene keeps the moisture in. The polythene bag comes back to the C.S.S.D. with its set of dirty instruments without being touched by the nurse.

Disposal: Nurse picks up the disposable clinical sheet, rolls that up in her hand and plunges it into the gallipot so that any excess solution in the gallipot is absorbed in the clinical sheet. She rolls this up in the sterile field. The whole thing is disposed of in one go, including the gallipot, into the newspaper cone which is the traditional method of disposing of soiled dressings on the district or into the patient's boiler or fire, leaving an empty table.

Is it difficult to burn all this aluminium? Unless the patient has a roaring boiler, it is best to tip the solution out of the gallipot which is put in the patient's dustbin. The gallipot has not been near the patient, and it can be disposed of in this way, if the fire will not burn aluminium. The rest goes on the fire.

* * * * *

While nurses on the platform demonstrated dressings using conventional techniques and using the technique adapted to C.S.S. packs, Dr. Darmady answered questions from the audience.

Mrs. Mee (Cambridge):

What happens about disposal of dressings in smokeless zones?

Dr. Darmady:

Arrangements can be made in the ordinary way to have certain dirty dressings picked up by the local authorities. This has already occurred in some districts where they have smokeless zones.

Miss Borchard (Aylesbury):

Has there been any difficulty in getting the special packs, such as those by Johnson & Johnson, prescribed by a doctor?

Dr. Darmady:

At the moment there is no way in which a doctor can prescribe the special dressing packs. I feel it would be a logical step forward to do so. It would save the nurse's time and would save in materials. We are very grateful to Messrs. Johnson & Johnson for providing all these packs free for this trial.

Miss Mansbridge (Cumberland):

Can you give any figures as to what the C.S.S.S. is likely to cost?

Dr. Darmady:

I am always very careful about these financial questions. I suspect it will cost more than the present system. This is inevitable because we are providing materials which are separately wrapped. This will ensure that the dressings are sterile and will be saving the nurses a considerable amount of time. Other than that, I cannot give an idea of cost, because the study has been carried out for such a short while. Cost will also depend both on the instrument reprocessing, and whether the dressings come from manufacturers or from the hospitals.

Miss Davies (West Sussex):

Can you tell me whether student nurses in Portsmouth hospitals are taught this new method only, and if they

emerge as state registered nurses knowing only this method, and not the old?

Dr. Darmady:

At the moment they are taught both systems.

Miss Grazier (Bristol):

Have you evolved a system of delivering dressings and syringes to the nurse's home?

Dr. Darmady: Yes.

Miss Grazier:

Does the nurse always have to have a car?

Dr. Darmady:

At the present moment we have arrangements whereby our van delivers to the particular nurses' house or nurses' homes. There are certain improvements which I would like to make; in particular I would like to see dispensers of fifty dressing packs at a time or alternatively, what I hope will come, the doctor will prescribe the necessary dressing packs on an E.C.10 form so the patient can have them ready at his home when the nurse calls. This would have to be decided by the Government.

All of our experiments at the moment have been made with cars, but I have something which I feel is a good idea for carrying syringes. This can easily be made to carry forceps and other instruments as well. (See photograph.)

Photograph by courtesy of Nursing Mirror

The plastic case with zipped drop-side for carrying sterilised equipment on the district

Miss Archer (Devon):

How long do these packs of dressings remain sterile?

Dr. Darmady:

We have kept packs up to a year and they have remained sterile. We have kept some on the move in our vans, some lying loose in doctor's bags and others left lying on shelves. I would like to have a completely water-repellent paper for the outside of the pack. I am quite satisfied we have a seal which will make it completely bacteria-proof.

Miss Bryant (Exeter):

For three years we have used instruments not in tubes but in linen, but we have now changed to paper. We do about forty-five dressings a day and forty injections, and it is a great saving in time.

Dr. Dunning (Oldham):

What are the objections to the use of the cartridge syringe by the district nurse for the ordinary injection?

Dr. Darmady:

There is no objection to this, but there is considerable difficulty in cleaning the nozzle of the needle itself. This means we have to provide a syringe with the end screwed to the bayonet which perforates the cartridge. This has proved very costly to process in the syringe services. It is hard to re-sterilise, and at the moment we cannot clean it satisfactorily enough to put it into common use.

Miss Borchard (Aylesbury):

What do you use for lotion with swabs?

Dr. Darmady:

This is another subject which Dr. Verdon recently investigated in order that there might be some standardisation of lotions for cleaning the skin prior to injections. As a result of skin tests with twelve well-known solutions found on all wards, the most efficient was a solution made by Allen & Hanbury called Laurolinium; this is used on C.S.S.D. wards for this purpose only.*

* * * * *

Summing up, the chairman, *Sir Zachary Cope*, said:

"I think in the next ten years you will note central sterilisation will develop in many parts of the country, particularly those in which there are small hospitals where it is difficult to carry out the more complicated methods. A centre which can send out sterilised dressings and syringes like that will be of incalculable value to the nurse in any district,and to the doctor who may be practising in a part where it is difficult to get sterilisation carried out.

"That sums up the thing we have learned today, that we have a method here which is almost bound to develop, which will enable work to be done in remote parts with sure sterilisation with less trouble. I do not know about the expense, but if it is the best method, it will have to come".

Proposing a vote of thanks, *Dr. Royd* (Senior Medical Officer of Health, Manchester) said:

"Dr. Darmady has given us a very clear lecture this afternoon. It is very seldom one has the opportunity of hearing a new subject presented so clearly, so simply, with a mass of data so easy to comprehend.

"One little niggling fear I have, and that is, that we should not talk too much about increasing the case load of the district nurses. They have a function, as social welfare officers if you like, in the sense that they have another job besides nursing the sick. (*Hear, Hear.*) This is not the place to discuss it, but if they can save five or ten minutes from boiling a syringe, they can talk to the patient, and give that reassurance that the patient needs". (*Applause.*)

* Verdon P.E. 1961 *J. Clin Path* **14**, 91.

Reprints of this report in leaflet form will be available from:
Circulation Department, District Nursing, 57 Lower Belgrave Street, London, S.W.1

The District Nurses' Examination

TWO hundred and seventy nine candidates presented themselves for the district nurses' examination held in May 1961 and 261 passed the examination. Eleven candidates reached the standard necessary for the distinction awarded by the Queen's Institute of District Nursing.

The answers showed a lack of applying knowledge to different circumstances and revealed apparent inability on the part of candidates to glean information from observation visits and reading.

Question 1

Several candidates attempted to answer all five of the sub-questions; only four were asked for. Qualifications and conditions of employment of the various officers were gone into at great length, whilst duties only were necessary.

The purpose of this question was mainly to assess the candidate's own knowledge as to which aspects of her field of work would bring her into contact with these officers. (*a*) Medical officer of health: As members of the public health team, prospective district nurses should know some of the duties of the head of the team; otherwise, how can they co-operate with him and be loyal to him?

Most candidates knew the services provided by the local health authority but they did not seem to realise that the medical officer of health of a county or county borough has the overall responsibility. In most major local health authorities, the M.O.H. is also the chief school medical officer and as such is responsible for the school health service.

Very few candidates mentioned the duties of the medical officer of health of a municipal or metropolitan borough, where he is responsible chiefly for the environmental health services. He also deals with additional aspects of the care of the aged and undertakes many kinds of health education.

One candidate wrote only that the medical officer of health "is dismissed by Parliament".

(*b*) Disablement resettlement officer: The name itself is so descriptive that candidates should have known some of this officer's duties. District nurses meet many disabled people and should know whom to contact when help concerning resettlement into employment is required.

(*c*) Children's officer: This officer was described by one candidate as "dealing with neglectful children". It is important for a district nurse to know that in any situation where a child is deprived of normal home life, the children's officer will help. The wide range of work done by the children's department of the major local authority in connection with any children who are not cared for in their own homes, should be known by district nurses.

(*d*) The duties of the psychiatric social worker, were reasonably well described although several candidates did not appreciate that this officer may base her work on hospital units, on local health authority establishments, or may carry out her duties in connection with the responsibilities of the local education authority concerning school children. One candidate was under the impression that the psychiatric social worker deals exclusively with old people.

(*e*) National Assistance Board: All district nurses should know how the National Assistance Board discharge their duties of helping those in need. They receive and investigate applications for help, visit applicants, and give grants in money or kind to meet the special needs of individual people.

Question 2

This was very well answered by the candidates who attempted it.

The underlying principles of the Mental Health Act 1959 are: (i) to remove the stigma of mental illness and change the attitude of the public toward mental disorder of all kinds; (ii) to facilitate admission to hospital, thus ensuring early treatment; (iii) to facilitate discharge from hospital, thus encouraging voluntary admission; (iv) to merge patients suffering from mental sub-normality and mental illness into one group of patients showing signs of mental disorder; (v) to preserve the liberty of individuals to the greatest possible degree.

The most important changes are: (*a*) repeal of the Lunacy and Mental Treatment Acts 1890 to 1930, and the Mental Deficiency Acts, 1913 to 1938; (*b*) dissolution of the Board of Control: its rights, liabilities, obligations and property being transferred to the Minister of Health; (*c*) constitution of mental health review tribunals, one in every area of the regional hospital board; (*d*) new terminology: mental disorder, mental sub-normality, severe sub-normality, psychopathic disorder; (*e*) mentally sub-normal children will be compelled to attend regularly at training centres in lieu of education; (*f*) admission to a psychiatric hospital will be on

THE QUESTIONS

*Time allowed for examination: three hours. Important—***two** *questions only to be answered in Part I and* **four** *in Part II*

PART I

Two questions only to be answered from this section

1. Outline the duties of four of the following: (*a*) medical officer of health. (*b*) disablement resettlement officer. (*c*) children's officer. (*d*) psychiatric social worker. (*e*) National Assistance Board.
2. What are the most important changes brought about by The Mental Health Act 1959 [Mental Health (Scotland) Act 1960]?
3. How can the district nurse co-operate with the health visitor and hospital almoner in the interest of the patient?

PART II

Four questions only to be answered from this section

4. The incidence of accidents in the home is increasing. What suggestions and advice should the district nurse give to: (*a*) an elderly patient who is not bedridden but lives alone; (*b*) the relatives with whom an elderly patient is living.
5. The district nurse is visiting a patient, suffering from advanced carcinoma of the lung, to administer morphine. What observations should be made and what records kept? What help and advice could be given to the family who are able to carry out the nursing care?
6. In what conditions would a report on the patient's urine be indicated? What information for the general practitioner can a district nurse obtain and how?
7. How can a district nurse supervise the nursing care of a sick child at home? In what circumstances would hospital admission be advisable?
8. What help can be given to a young woman suffering from disseminated sclerosis to enable her to maintain the maximum degree of independence?

the recommendation of two medical practitioners, one specially trained in psychiatry, the other acquainted with the patient if possible; no magistrate's order will be required.

A district nurse is in a better position to advise a patient or relative if she has a knowledge of this progressive attitude toward mental illness.

Question 3

Co-operation with the almoner seemed on the whole better understood than that with the health visitor. Poor co-operation in practice must be the cause of this lack of knowledge. Several candidates confined themselves to the young child as the point of contact between health visitor and district nurse; but surely it is more likely to be in the realm of the aged and physically handicapped that health visitor and district nurse can co-operate in the patients' interests.

Question 4

Some candidates ignored completely the introductory statement on the incidence of home accidents and gave general advice only. Much good text-book information on the prevention of home accidents was given, but few candidates applied it to the specific circumstances quoted in the question. The psychological aspect of relationships between the aged and their families; the inconspicuous precautions the family should take without upsetting the old relatives' way of life; and the danger of smoking in bed were seldom mentioned.

Question 5

District nursing is much more than giving specific treatment. In this particular case, the district nurse must be very alert to changing circumstances. Although it is often easier to carry out the actual nursing duties, the nurse should respect the wishes of the relatives who may be anxious to give the most intimate nursing care themselves. However, the nurse must know when to increase her visits; she must observe symptoms of tiredness and strain and thus prevent mental breakdown. The Marie Curie Memorial Fund and their night nursing service was mentioned by few candidates only. Advice on the safe keeping of dangerous drugs should have been given.

Question 6

Few candidates attempted this question, although every state registered nurse is familiar with conditions in which a report on the urine would be an important guide to diagnosis and assessment of progress. Several candidates confined themselves to urine testing in diabetic conditions, and few mentioned the reports about amount, colour and smell of urine.

Question 7

The first part of this question allowed for anyone's imagination to have full scope. Depending on the condition of the child, teaching about the spread of infection, play materials, and mental preparation for possible hospital admission, could have been enlarged upon. Candidates did not seem to realise that the mother could have a home help to make it easier for her to nurse her child at home. Most candidates mentioned only social reasons for hospital admission; surgical treatment, special tests, the need for special diet, and the mental conditions of mother or child would be other potent reasons for admission.

Question 8

This question was well answered on the whole and most candidates kept the patient ambulant as long as possible. More mention should have been made of the local authority welfare department, which will undertake adaptations of the home to make life easier. It is better to enable this woman to cope with her normal household tasks rather than to create artificial hobbies for her. Voluntary agencies like the Multiple Sclerosis Society were mentioned by few.

District Nurses' Examination Pass List

The following have passed the Institute's examination and have been enrolled as Queen's nurses from 4th May 1961. All those trained in England and Wales have qualified also for the national certificate of the Ministry of Health.

†Distinction awarded by the Queen's Institute.

ENGLAND AND WALES

Birmingham
Carlos, Veronica
Cope, Betty Annie
Corfield, Margaret Elizabeth
Hector, Ruth Eileen
Hitchin, Caroline Nairn
Kinsey, Annie Isabel
Walters, Maud Deluta
Williams, Patricia Maud

Bolton
Howard, Jean

Bradford
†Bailey, Margaret Elsie
Bullock, Edna
Graham, Stella Mildred
Higgins, Margaret Roma
Moverley, Vera Freemantle
Murray, Joyce
Sowerby, Jeanie Elizabeth

Brighton
Justice, Maureen Ann Christina
Peters, Jutta Anna Ursula
Quaintance, Mary

Bristol
Bill, Jean Catherine
Clemow, Rachel Anne
Davies, Mary
Molineux, Linda Mary
Paice, Katherine Irene
†Rendle, Lois Peggy
Robinson, Beryl Christine
Rowlands, Jean

Brixton
Ricketts, Marjorie Evadne

Camberwell
Cochrane, Geraldine Evadne
Forbes, Patricia Eleanor

Coventry
Gannon, Annie Frances
Meadowcroft, Jean
Norris, Sheila Margaret
Robinson, Joan Margaret
Saunders, Christine
Tonge, Patricia Ann
Yates, Diana Jacqueline

Croydon
Harkin, Mary Catherine
Linsell, Olive Muriel
Masson, Margaret Kinnear
Miller, Maria Molly Elvy
†Parsons, Miriam Elsie
Stephen, Doris Mary

East London
Cannock, Elizabeth Helen
Donaldson, Shirley Mae
Keay, Doris Valerie
Keay, Elizabeth
Menzies, Dorothy Evangeline
Williams, Menai Llewelyn

Essex County
Arundel, Maureen Teresa
Calvert, Virginia Marie
Daly, Julia Esther
Gallagher, Mary Brigid Philomena
Hayles, Leilah Carmetta
Long, Jennifer Mary Kate
McMillan, Jean Lillian
Nze, Victoria
Renshaw, Dorothea Mabel
Wright, Jean Margaret Kathleen

Gateshead
Jobson, Gladys

Gloucester
Amphlett, Rosamond Ann
Aremo-Usidame, Rosebud Odion
Davey, Norah Elaine
Green, Sheila Teresa
Greening, Valerie Diana
Miles, Hilda Mary
Russell, Mary Teresa
Weaver, Bronwen Ann

Guildford
Adams, Merle
†Burrows, Brenda
Durrant, Margaret Eileen
Glover, Margaret Anne
Newman, Dorothy Mary
Solesbury, Jean Rosemary

Hackney
Campbell, Emma Pearlesta
Gamage, Marina Mary
Law, Edna Eleith

Halifax
Browes, Olive Mary
Drake, Margaret Alice

Green, Clara
Hey, Margaret
Levis, Marjorie Isabel
Snell, Lorna Marie

Huddersfield
Brookes, Kathleen
Crabtree, Christine
†Fender, Dorothy Ann
Horsfall, Mary
Moran, Kathleen Mary

Kensington
Cointre, Lucienne Odette
McCaul, Mary
O'Mahony, Mary Winifred
Taylor, Meryll Gladys
Ward, Bridget Mary

Lancashire
Atkinson, Marina
Boulter, Doreen
Brough, Joan Hannah
Calderley, Dorothy Margaret
Dawes, Margaret Mary
Deshpande, Leela Suresh
Hughes, Constance Mary
Hughes, Mary
Johnson, Eileen Florence
Pilkington, Constance
Rushton, Francis
Watling, Catherine Teresa

Leicester
Boorman, Bertha
Green, Kenneth Leonard
Hancock, Charles Augustin
†Hussey, Daphne Gwendoline

Liverpool
Booth, Helen Mary
Braid, Rose
Breen, Bridget Teresa
Dainty, Peter Brian
Davidson, Alice Mary
Ellison, Frances
Harrison, Minnie Margaret
McCann, Margaret
McGiveron, Doreen Evelyn
Preston, Gertrude

Manchester (Harpurhey)
Choong, Gracie Poh Ying
McWatt, June Margaret
Teague, Muriel Margaret

Metropolitan
Brown, John Milner
Huggett, June Mary
Hughes, Dorothy Griffith
Hunnisett, Elizabeth Frances
Mbanefo, Elizabeth Udegbunam

North London
Amos, Sylvia
Jokoto, Agnes Keinde
Walker, Daphne Veronica
Williamson, Ruby May

Nottingham
Foxton, Rosita Ann
Guthrie, Bellzie Unice

Oxford
Bettinson, Patricia Anne
Dunlop, Winifred
Gall, Emily Marguerite Forster
Jackson, Roberta Irene
Missirian, Yeranik
Phillips, Anne
†Sankey, Margaret Irene
Sutcliffe, Brigit

Paddington
Watson, Clara
Wright, Chrisetta Meldora

Plymouth
Collier, Queenie Joyce
†Hooper, Helen Patricia
Rich, Molly
Stanbury, Marjorie Violet

Portsmouth (Hilsea)
Ballingall, Helen Smith
Bolwell, Jean Emmeline Alice
Bowyer, Clarice Ivy
Melsome, Joan Marcia
Pyner, Sheila Patricia

Portsmouth (Southsea)
Lloyd, Angela Mary
†Lyon, Shirley Eve
Miles, Christine Ann
Salter, Jacqueline Margaret

Rochdale
Archer, Beatrice Doreen
Byrne, Doreen
Chicot, Florence
Jones, Norma

Rotherham
Jackson, Maureen
Leaver, Annice
Swift, Sonia

St. Helens (with Liverpool)
Moore, Margaret Mary

St. Olaves
Burns, Mary Christine
Creary, Jacqueline Theresa

Salford
Nolan, Mary

Sheffield (Johnson Memorial)
Caine, Violet Daphne Adassa
Lander, Wendy
Thomas, June Margaret

South London
Herd, Mary Eleanor

Stockport
Goddard, Edith

Surbiton
Brett, Barbara Ann
Clarke, Elizabeth Mary Crawshaw
Hall, Carolynn Mary
Mott, Sylvia May
Hunton Young, Mary Jane

Wallasey (with Liverpool)
Blease, Edith Margaret
Jones, Bessie Eleanor

Watford
Atherton, Sally
Chapman, Doreen Rosita
Gilman, Pauline Mary
Hickie, Alice Bessie
Mitchell, Rosemary Elizabeth
O'Sullivan, Kathleen Philomena

Westminster and Chelsea
Bannister, Audrey Jean
Brogan, Irene May
Evanson, Muriel
French, Sally Ann
Hayward, Teresa Anne
Le Cornu, Alice Monamy
McGlade, Doreen Elizabeth Elsie
Moss, Yvonne Ann
Oakley, Eileen Joy
Okundaye, Victoria Olubunmi

Woolwich and Plumstead
Dutton, Jean Frances
Gravells, Catherina May

Worcester
Foster, Eleanor Mary
Lloyd, Vivienne Rose
Newstead, Kathleen
Pownall, Patricia Margaret
Simister, Nancy Elizabeth

NORTHERN IRELAND

Belfast
Black, Valerie Elizabeth
Holden, Kathleen Margaret
Johnston, Margaret Frances
†McElroy, Isabella Rosaline
†Nelson, Marion
Williamson, Anna Mary

Londonderry
Breeze, Georgina

SCOTLAND

Aberdeen
Annand, Kathleen Helen
Campbell, Ishbel Reid
Lindsay, Elizabeth Lauretta
West, Esther Caroline Mackenzie

Edinburgh
Bannerman, Catherine Alexanderina
Black, Annie Crombie
Brown, Annabella Ross
Campbell, Mary Enid Nutting
Dawson, Elizabeth Yuill
Douglas, Anne Pollock
Frame, Elspeth Mary
Gilland, Grace Ann
Green, Jane Ann Lindsay
Hogg, Fiona
Hossack, Alice Robertson
Isdale, Grace Cameron
MacDonald, Alexandra
Macdonald, Donalda Mary
Mackay, Rodina
McKelvie, Janet Chalmers Henry
Mackenzie, Flora Bell
MacLellan, Catherine Theresa
MacLeod, Janet Ritchie Mair
Martin, Norah Ann
Nicolson, Mary Ann
Oliver, Margaret Gibson
Rankin, Helen Fairbairn
Saunders, Patricia
Stangoe, Jane Hamilton Park
Stiell, Isobel Mary
Stoddart, Margaret Ann
Stout, Laura Ann
Toman, Joseph
Watson, Margaret McKenzie
Wood, Ella Catherine

Falkirk
Miller, Margaret

Glasgow
Kelly, Mary Cochrane McIntosh
Macdougall, Anne MacFarlane
McGinty, Mary Catherine
MacKenzie, Margaret Collins
MacLeod, Mary
McMillan, Annie Jessie
Morrison, Joan Anne
Park, Janet Elizabeth

EIRE

Dublin
Bouchier-Hayes, Agnes Mary
Kiely, Julia Teresa
McEnroe, Kathleen
Morgan, Catherine Mary

The following has passed the examination and has been enrolled as an overseas Queen's nurse from 4th May 1961.

East London
Fox, Edith Elaine (superintendent, Hyacinth Lightbourne Visiting Nursing Service, Jamaica)

The following have passed the examination and have qualified as Ranyard nurses and for the national certificate of the Ministry of Health.

Ranyard Nurses
Mathie, Christina Sinclair Baillie
Saunders, John William
Williams, Francesca Jane Beatrice

A Course with a Difference

"A VERY interesting and stimulating course. I thought the lectures were well planned and could not have been improved upon. It has given me much food for thought and will certainly help me in teaching students."

"I would like to say how much I enjoyed the lectures. I believe that if these lectures were given regularly, they would be a very great help to all district nurses."

These were among the anonymous comments made by twenty experienced district nurses who took part in a short experimental course held at the Queen's Institute last month. Surely, not another course? Yes, another course—but with a difference.

Every Queen's nurse remembers most vividly her first few days on the district and the long-suffering, patient, helpful senior nurse who introduced her to this work. What a help she was. The student district nurse reaches out eagerly for any information she can obtain from every source, the practical demonstrator being one of her most important sources of help. Furthermore, as student hospital nurses, student health visitors, medical students, overseas visitors and others come out to observe district nursing, what great opportunity, but also responsibility, our senior nurses have. How can district nursing in its full scope be presented to anybody in one morning?

At the beginning of our special course, twenty senior members of the profession looked at themselves as this question was put to them: Do you enjoy explaining, demonstrating, and teaching other people your job? Or are you relieved when the visitor is allocated to someone else? If you prefer to be left alone, this may be due to two reasons: either you are not really interested yourself, or you are not completely at ease with others and find explaining difficult.

The fact that the audience were senior district nurses ruled out the first reason: nobody could be a nurse for years without interest. The course was designed to help those who, although excellent at their job, might find it worrying and difficult to explain and demonstrate to others.

The opening remarks set the tone. The reason why—why students, why visitors, why a special course? Miss Hellier, speech expert from the Abbey School of Speakers, followed by presenting to the group the challenge of their own valued profession. She used the apt picture of the old centipede who was asked by the toad which leg he was going to use next; at that moment the centipede stumbled. Years of devoted, skilful, efficient service—how do we do it? can we explain?

"Although I still believe teaching is a gift which I am not favoured with" was another comment, "I have been greatly helped by the realisation that the principles of teaching can be followed by anyone who knows them."

There are two main principles: (1) from the known to the unknown; and (2) whole before part. Every piece of teaching, whatever it may be, begins to make sense when these two simple rules are observed.

The next lecture was on people: this includes our patients, our students, our visitors, our colleagues, our employers and ourselves. How different and yet how alike we are in our fears, needs and desires. Do we know ourselves, have we sorted out our true motives? Are we still as anxious to help our patients as we were when we first embarked on our career or have we caught the current conveyor-belt attitude? Do people matter more to us then money, reputation and temper?

The changing pattern of living and its effect on our work was the topic of the next lecture. Are we still holding on to methods which met the needs years ago or are we adapting ourselves and our techniques to the ever changing environment? This lecture widened our vision and formed an excellent background for the next one, which dealt with the best use of social services.

It is on the district, in the course of the daily round, that the student can be helped to see the practical application of the social services mentioned during her lectures. Nurses were reminded of this by the lecturer who took us on a hypothetical round, demonstrating instances where the help of statutory and voluntary agencies could be enlisted for the well-being of the patient and the family.

Miss Hellier initiated the last, practical session with a few helpful remarks about catching and continuing interest. The course closed with each member giving a two-minute talk on some aspect of her work, which received humourous yet firmly instructive criticism from Miss Hellier. This was a profitable and enjoyable exercise; after all, apart from our jobs, it is always useful to be able to speak clearly and with interest. **L.H.**

Obituary

Mrs. Elizabeth Markham

WE report with regret the death of Mrs. Elizabeth Markham (*née* Davis) on 12th May.

Mrs. Markham took her general training at Nottingham General Hospital from 1939 to 1943, and after three years with the Q.A.M.N.S. she took midwifery and district nurse training in Glasgow. She subsequently worked in Glasgow, the Isle of Man, and as assistant superintendent in Nottingham. She resigned for home duties in 1955.

Mrs. Markham endeared herself to all who knew her, both patients and nurses. As an administrator she was an admirable colleague and she maintained her interest in all our affairs after leaving us for the birth of her first infant. Indeed this interest was maintained up to a few hours before her death. Mrs. Markham died in her own training hospital, where the nurses spoke of her courage throughout her illness.

Mrs. Markham was an inspiration to all. We shall always retain memories of her as being a person who was so selfless and who showed such interest at all times in the other person. **M.M.K.**

CLASSIFIED ADVERTISEMENTS

Advertisements for this section can be received up to first post on the 2nd of the month for publication on the 10th. They should be sent direct to: District Nursing, 57 Lower Belgrave Street, London, S.W.1. Telephone Sloane 0355.

Rates: Displayed Setting: 17s. 6d. per single column inch: £2 per double column inch. Personal, 2½d. per word (minimum 12 words, 2s. 6d.): all other sections, 3d. per word (minimum, 12 words 3s.). Ruled border 5s. extra

COUNTY BOROUGH OF SOUTHEND-ON-SEA
Appointment of Deputy Superintendent of Home Nursing and Midwifery Services

Applications are invited for the above appointment. Applicants should be S.R.N., S.C.M., and possess a certificate of training in district nursing. Salary £761 × £31(2) × £32(2)–£887.

The appointment is subject to the Local Government Superannuation Acts, and to a satisfactory medical report from the corporation's medical examiner.

Particulars of appointment and forms of application can be obtained from the Medical Officer of Health, Municipal Health Centre, Warrior Square, Southend-on-Sea, to whom applications should be returned not later than two weeks from the date of this advertisement.

ARCHIBALD GLEN, Town Clerk

CITY OF COVENTRY
Health Department
Assistant Superintendent
District Nurses' Home (Training)

Applications are invited from those with appropriate qualifications and considerable experience in a Home Nursing Service of a local health authority.

Salary scale within the range £735–£866.

£26 payable in certain circumstances. Residential post. £225 deducted for board and lodging.

Application forms and full particulars from Medical Officer of Health, New Council Offices, Coventry, returnable by 24th July 1961.

SOMERSET COUNTY COUNCIL
Midwifery and Nursing Services

Two Area Nursing Officers required—applicants must possess S.R.N., S.C.M., and health visitors's certificates, and be qualified under Midwives' (Qualifications of Supervisors) Regulations; preference given to Queen's nurses. Previous experience in whole-time health visiting, supervision of premature infants desirable. Motorists essential. Travelling allowances. Salary £877 to £1,034. Superannuable posts.

Further particulars from County Medical Officer of Health, County Hall, Taunton.

HEREFORDSHIRE COUNTY COUNCIL

Applications are invited for the following appointments:

Ewyas Harold, south-west Herefordshire. District nurse/midwife or district nurse/midwife/health visitor; duties according to qualifications. Rural area. New house, furnished or unfurnished. Motorist—car provided or allowance for own car.

Hereford. District nurse/midwife or midwife. Modern house, furnished or unfurnished. Motorist or willing to learn.

Application forms and terms of appointments may be obtained from the County Medical Officer, 35 Bridge Street, Hereford.

CITY OF OXFORD
Health Department
Assistant Superintendent for Queen's Training Home

Experienced Queen's Sister required to act as District Nurse Tutor (up to eight students, study-day system of training) and to deputise for the Superintendent in her absence. Must hold Health Visitor's Certificate. Motorist essential. Resident or non-resident. Salary according to Nurses and Midwives Whitley Council. Application forms obtainable from the Medical Officer of Health, Health Department, Greyfriars, Paradise Street, Oxford, to whom they should be returned.

Town Hall, Oxford — HARRY PLOWMAN, Town Clerk

CUMBERLAND COUNTY COUNCIL
(Affiliated to the Queen's Institute of District Nursing)

1. **District Nurse/Midwife/Health Visitors**
   - (*a*) **Bothel**—one required
   - (*b*) **Wigton**—one required
   - (*c*) **Longtown**—two required, suit friends
2. **District Nurse/Midwives**
   - (*a*) **Maryport**—two required, suit friends
   - (*b*) **Millom**—one required, new flat available

Furnished or unfurnished houses available and cars will be provided for all the above appointments.

3. **Queen's District Training**

Applications are invited from nurses S.R.N., S.C.M., wishing to work as district nurse/midwives in Cumberland. Arrangements can be made for them to take three or four months training at an approved Queen's nurses' training home.

Further particulars and application forms obtainable from The County Medical Officer, 11 Portland Square, Carlisle.

DEVON COUNTY COUNCIL
(Member of Queen's Institute)

District Nurse/Midwives, preferably with Queen's training, for combined midwifery and general duties for the following areas. Car provided, or allowance for use of own.

Anstey, near South Molton
Barnstaple. Flat available
Bradworthy, near Holsworthy. House available
Horrabridge, near Tavistock. Lodgings at present, house later
North Molton. House available
Parkham, near Bideford. Lodgings at present, house or bungalow later
Whiddon Down, near Okehampton. House available
Winkleigh, near Torrington. House available
Shaldon, near Teignmouth. House available

Accommodation provided can be either furnished, or unfurnished, according to requirements. Apply for conditions to the County Medical Officer, 45 St. David's Hill, Exeter.

WARWICKSHIRE COUNTY COUNCIL

Applications are invited for the undermentioned vacancies. Where house or other accommodation available this can be either furnished or unfurnished. Consideration will be given to the granting of financial assistance towards removal expenses and for driving tuition. Motorists can receive allowance for own car or car will be provided.

District Nurses, District Midwives, District Nurse/Midwives

Area 2*a*—**Atherstone** (rural). One district nurse/midwife. Motorist. House suitable nurse with relative.

Bedworth (urban). District midwife. Motorist. House.

Area 3—**Rugby** (town). District nurse. Motorist. Flat.

Area 4—**Coleshill and District** (urban and rural). District nurse/midwife. Motorist. Flat.

Castle Bromwich and District (urban). District nurse/midwife. Motorist. House.

Kingshurst (urban). District nurse/midwife. Motorist. House.

Wilnecote and District (urban and rural). District nurse/midwife. Motorist. Flat.

Area 6—**Warwick and District** (urban and rural). District nurse/midwife. Motorist. Accommodation.

District Nurse/Midwife/Health Visitors

Area 3—**Birdingbury** (rural). One required. Motorist. Modern flat.

Brinklow (rural). One required. Motorist. Modern flat.

Clifton-on-Dunsmore (rural). One required. Modern flat. Motorist.

Health Visitors

Area 2*a*—**Bedworth** (urban). One required. Motorist.

Area 6—**Leamington Spa** (town). One required. Accommodation.

Area 7—**Stratford-on-Avon** (town). One required. Modern flat.

Application forms and full particulars may be obtained from the Area Medical Officer as follows:

Area 2*a*—Health Department, Council House, Nuneaton; Area 3—Health Department, Albert House, Albert Street, Rugby; Area 4—Health Department, Park Road, Coleshill, Birmingham; Area 6—Health Department, 38 Holly Walk, Leamington Spa; Area 7—Health Department, Arden Street, Stratford-on-Avon.

The Council is a member of the Queen's Institute of District Nursing.

Shire Hall, Warwick — L. Edgar Stephens, Clerk of the Council

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METROPOLITAN DISTRICT NURSING ASSOCIATION

District Midwife required for Central London area. Resident in nurses' hostel. Cyclist or motorist. Apply: Superintendent, 18–20 Montague Street, Russell Square, London, W.C.1.

Other Advertisements on p. 94

NORFOLK COUNTY COUNCIL

Vacancies now exist in the following areas:

District Nurse/Midwife/Health Visitor

Blofield. Pleasant rural area seven miles Norwich. Furnished accommodation for time being

Brooke. Seven miles Norwich. Attractive countryside. House provided

Feltwell. Adjoining Fen area. Nurse's house available

Stoke Holy Cross. Five miles Norwich. Attractive countryside. House provided

Tilney All Saints. Five miles King's Lynn. House provided

Tittleshall. Central Norfolk. Attractive countryside. Bungalow provided

District Nurse/Midwife

Gayton. Seven miles King's Lynn, vicinity of Sandringham. House available. Nurse's house to be built shortly.

Upwell. Rural area, near Wisbech. Unfurnished council house

District Midwife (S.R.N., S.C.M.)

Hellesdon. Fringe area of Norwich. Unfurnished house available.

Nurses should be motorists and may use their own cars (loans available for purchase) or cars can be provided. Assistance given to applicants who require driving tuition. House furnished if required.

Grant towards moving expenses will be paid.

Staff needed for relief duties, holidays and longer periods—must be mobile. Application forms from County Medical Officer, 29 Thorpe Road, Norwich, Norfolk, NOR 01T.

Health Visitor Scholarship

Facilities available for health visitor training for full-time and generalised appointments.

Queen's Nurse Training

Courses arranged for state registered nurses (usually with S.C.M. certificates) for work in the county.

COUNTY BOROUGH OF TYNEMOUTH

Public Health Department

Applications are invited from female State Registered Nurses, preferably district trained, for the appointment of **District Nurse.** Whitley Council salary scale.

Unfurnished housing accommodation will be available, if essential.

Application forms, endorsed with conditions of service, can be obtained from the Medical Officer of Health, Public Health Department, Albion Road, North Shields, Northumberland, to whom they should be returned by 22nd July, 1961.

FRED. G. EGNER
Town Clerk

SOMERSET COUNTY COUNCIL

Midwifery and Nursing Services

Senior Health Visitor—Weston-super-Mare. Required September. Group of five health visitors which will increase. Salary £719 to £903.

There are vacancies in the following areas for health visitor/school nurse:

Yeovil

Frome (east Somerset)

Radstock (mid-Somerset)

Motorists or willing to learn (financial help given with driving tuition). Car provided or allowance paid.

Further particulars from County Medical Officer of Health, County Hall, Taunton.

GLOUCESTER DISTRICT NURSING SOCIETY

State Certified Midwives required for whole-time domiciliary midwifery. Also one domiciliary midwife required for night-duty only. Apply to the Superintendent, 14 Clarence Street, Gloucester.

NEW AUSTIN CARS

Reduced Hire Purchase and Insurance rates to members of Nursing Profession. Seven, A.40 and A.55 Saloons from £108 1*s* 4*d* down, 36 monthly instalments £14 4*s* 7*d*. Also Morris Minor and Mini-Minor Saloons. Free Brochures. Austin House (D.N.), Highfield, London, N.W.11.

QUEEN'S INSTITUTE OF DISTRICT NURSING

District Nurse Training

Courses of approved training to qualify for the Queen's Roll and the national certificate in district nursing are available to state registered nurses on the general register.

Further details may be obtained from the Education Department, Q.I.D.N., 57 Lower Belgrave Street, London, S.W.1.

QUEEN'S INSTITUTE OF DISTRICT NURSING

Bursaries for Public Health Tutor Courses

Two bursaries of £400 each are being offered by the Queen's Institute to enable Queen's Nurses to take one of the following courses at the Royal College of Nursing, beginning in September, 1961.

(*a*) District Nurse Tutor Course

(*b*) Health Visitor Tutor Course

Applicants must hold the Health Visitor's Certificate and have had wide experience in district nursing, including generalised service or full-time health visiting.

Further information may be obtained from the Education Department, Q.I.D.N., 57 Lower Belgrave Street, London, S.W.1.

MIDDLESEX COUNTY COUNCIL

County Health Department

Domiciliary Midwife required in Area 4 (Finchley and Hendon). Must be S.C.M. and preferably S.R.N. N.M.C. salary plus London weighting. Uniform provided. Furnished accommodation available. Should be able to drive a car. Car allowance. Established. Prescribed conditions. Particulars and two referees to Area Medical Officer, Town Hall, Hendon, N.W.4 immediately. (Quote G.580 D.N.J.)

QUEEN'S INSTITUTE OF DISTRICT NURSING

William Rathbone Staff College

Course in Community Health Administration

Applications are invited from General State Registered Nurses who are (a) district nurses, midwives or health visitors with at least three years' experience in the field; or (b) hospital sisters with at least three years' post-certificate experience who wish to gain a wider knowledge of public health nursing, for the three-month residential course begining on Thursday, 14 September, 1961.

Scholarships are available for nurses from Co. Durham, Sunderland, London and other areas.

Further details may be obtained from The Principal, William Rathbone Staff College, 1 Princes Road, Liverpool 8.

QUEEN'S NURSES' BENEVOLENT FUND

Founded in 1913 *by Queen's Nurses, for Queen's Nurses*

Minimum subscription FIVE SHILLINGS a year.

OBJECT—To assist financially colleagues who have to give up work owing to illness.

APPLICATIONS for financial assistance may be made for a GRANT, after three consecutive subscriptions previous to going off duty owing to an illness of short duration have been paid, and after salary rights have been exhausted. *OR*

AN ANNUITY, after five consecutive subscriptions have been paid up to time of going off duty, when the illness involves resignation from District Nursing, and the applicant is unable to undertake other work.

SUBSCRIPTIONS should be sent to Miss Ivett, St. Anthony's, Marine Hill, Clevedon, Somerset from whom further details can be obtained.

An Annual Report, with a renewal notice, is posted direct to all subscribers each year.

Queen's Nurses Personnel Changes

APPOINTMENTS

Superintendents etc.

Hayes, C. M., Deputy Supt., Blackburn—Flexman, J., Asst. Supt., Sheffield—Ogborne, D. Asst. Supt., Birmingham

Nurses

Baker, D., Berks.—Barnes, J. E., Cumberland—Buxton, P. S., Somerset—Cain, E., Lancs.—Clay, H., Yorks., W.R.—Cousins, T., Kilburn & W. Hampstead—Cumming, Mrs. E., Hampstead—Gosden, A. F., Dorset—Gray, Mrs. M. D., Bucks.—Hudson, Mrs. W. G., Cheshire—Jenner, J. E., Somerset—Johnson, Mr. B., Essex—Jones, Mrs. E., Middx.—Libby, Mrs. D. G., Berks.—Lisle, Mrs. S. F. M., W. Sussex—Lloyd, J. N., Berks.—McCann, M., Cumberland—Norton, Mrs. R., Burnley—Phelps, E., Berks.—Reece, S. E., West Ham—Turney, Mrs. M. E., Kent—Walton, L. A., Dorset—Wild, M., Yorks. W.R.

REJOINERS

Benjamin, Mrs. I., Berks.—Cates, P. E., Kent—Dolphin, B., Yorks. E.R.—Eyre, Mrs. M. J., Rotherham—Fell, Mrs. J., Cheshire—Francalanza, Mrs. J., Surrey—Hayes, Mrs. M., Bolton—Hastie, E. A., Warcs.—Leckey, Mrs. A. M., Manchester—Le Corney, E. M., Warcs.—McKiernan, A. S., Brixton—Matthews, Mrs. M. J., Cumberland—Parker, E., W. Sussex—Parry, Mrs. E., Salford—Potter, Mrs. I. M., Yorks. W.R.—Roberts, R. E., Camberwell—Wellock, Mrs. N., Liverpool

RESIGNATIONS

Ball, M. E., retirement—Brookfield, Mrs. R., retirement—Brown, Mrs. B. R., personal—Bulloch, I. J., retirement—Burton, I., mid. trg.—Cleak, J. B., marriage—Croker, A., personal—Downing, J. B., personal—Evans, F. S., personal—Finch, Mrs. M., personal—Flynn, N., other work—Forde, M., personal—Girling, Mrs. E. J., other work—Goolding, D. E., work in Tasmania—Gore, M., retirement—Haslam, P., retirement—Head, D. G., retirement—Lennon, Mrs. M. K., personal—Libby, W. M., retirement—Little, N., other work—McFadyen, Mrs. M., personal—Mansfield, Mrs. J. A., personal—Morgan, P. A., moving—Neale, M. E., work in Tasmania—Partington, Mrs. H., personal—Robinson, E. M., leaving district—Rufus, M. W., S.S.A.F.A.—Scott, E., marriage—Sheppard, Mrs. M., personal—Warnock, Mrs. M. V., personal—Webb, Mrs. E. M., retirement—Wilson, E. E., other work

Scottish Branch

APPOINTMENTS

Nurses

Bannerman, C. A., Clydebank—Black, A. C., Calderbank & Chapelhall—Campbell, M. E. N., Calderbank & Chapelhall—Coghill, Mrs. M. M., Edinburgh—Combe, E., Edinburgh—Cormack, R. L., Hamilton—Green, J. A. L., Edinburgh—Hogg, F., Dunoon—Lamont, C. M., Hamilton—MacDonald, A., Lewis, C.R.N.—Mackay, R., Bannockburn—McKelvie, J. C. H., Cumbernauld—Martin, N. A., Airdrie—Stoddart, Mrs. M. A., Edinburgh—Stout, Mrs. Laura, Edinburgh—Tinney, A., Nethybridge—Toman, Mr. J., Edinburgh

REJOINERS

Findlay, C. B., Ayrshire, C.R.N.—Maclean, B., Back

RESIGNATIONS

Christie, M. C., Kilmarnock, marriage—Currie, M., Stewarton, district nurse/midwife in Bermuda—Imah, N., New Deer, marriage—Kennedy, M., Fortingall, retirement—McCutcheon, I. H., Stranraer, marriage—Macintyre, M. B., Motherwell, retirement—MacKenzie, M. J., Nethybridge, retirement—MacLeod, A. M., Drumnadrochit, marriage—Owen, Mrs. J., Glasgow, home reasons—Smith, Mrs. M., Edinburgh, home reasons—Stewart, E. I., Clarkston, retirement

TRANSFER TO ENGLAND

Macleod, K., Greenock

The Association of District Nurses

ANNUAL DINNER

The annual dinner will be held on Saturday, 4th November 1961 at University Arms Hotel, Regent Street, Cambridge.

Tickets, price 27*s* 6*d*, may be obtained from Miss M. Lambert, Hedges, Quebec Road, Dereham, Norfolk.

Members desiring overnight accommodation are advised to make early application, as all hotels in Cambridge are much in demand.